**STATE OF WASHINGTON**
# FIRST STEPS
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TO: All First Steps Providers

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**SUBJECT: RESPONSE TO PROVIDER INPUT REGARDING ICM ELIGIBILITY SCREENING TOOL**

Thank you for your thoughtful input and responses to the proposed changes regarding the Infant Case Management (ICM) Eligibility Screening Tool. Your input, questions and concerns have been compiled below followed by the Department of Social and Health Services' (DSHS) responses.

First, let us begin by sharing that, as many of you pointed out, the criterion in this tool is somewhat more "stringent" than the previous version. Tough choices have to be made in order to meet the budget proviso. With these challenges we face, we also have opportunities. This budget reduction has allowed us to expand the definition of "parent" and many of you pointed out in your comments that the form is more streamlined. Another opportunity is in the form of a program shift. The purpose of Infant Case Management is to assist parents in accessing needed social, medical and educational services that improve the welfare of the infant. We will keep coming back to the parent(s) ability to access the necessary services for the welfare of the infant. If a parent can access services, there isn't as great a need for Case Management. This is where we believe a significant portion of the budget will be met. On the other hand, if a parent needs help to access services, you are there to assist them. To that end, you will be relied upon to provide qualified staff and sound professional judgment to determine what Case Management services, including the level of these services, are most appropriate for the low-income infants and their parent(s) that you serve.

The following is your input with our responses:

1. **Previously an ICM client had to be living with the biological parent, and according to the new draft guidelines it states it can be any person, besides foster parents, that have legal custody or is legally obligated to support the infant. Are we going to be able to bill ICM in the instances that say a grandparent has custody or someone else besides the biological mother?**

   Yes. This is one of those opportunities that we mentioned above. For a variety of reasons, not every low-income infant lives with its biological parent(s). Because ICM services are billed using the infant's ID, this change makes sense. ***REMEMBER:*** Documentation is critical to justify the types and level of services provided.

2. **Will providers be able to exercise their own discretion when a client does not fit into one of the risk criteria but is seen as high risk for abuse/neglect?**

   In the scenario described, the provider may consider checking the box "Current domestic or family violence". However, as a mandatory reporter, if you suspect a child is the subject of abuse or neglect, you must report it to CPS. Call 1-866-ENDHARM (1-866-363-4276) or visit http://www1.dshs.wa.gov/geninfo/endharm.html

3. **If a pregnant woman experienced domestic violence or had a CPS case during the pregnancy would they qualify for ICM? It seems if these two issues were present during pregnancy, they are more likely to escalate postpartum placing the infant at higher risk of abuse/neglect.**

   Domestic or family violence includes not only physical violence, but also the use of power and control over a victim. If the parent is fearful of the perpetrator *(who is an intimate partner or family member)* then the issue in Column A would be checked and the parent is eligible for a lower level of ICM services. During further screening, if the parent is able to access services on her/his own, then the provider would provide the lower level of services. If the parent is not able to meet the infant's basic needs because of the threat of violence, then it is appropriate to check the box in Column B. Documentation to support the level of service is required in the client file.

   If the provider suspects that the infant is at risk of abuse/neglect as a result of domestic or family violence, the provider is required to report this to CPS by calling 1-866-ENDHARM (1-866-363-4276) or visiting http://www1.dshs.wa.gov/geninfo/endharm.html

4. **Please consider adding past domestic violence to Column A so that it matches explanation of criteria.**

   The explanation was changed to meet the intent of the criteria in Column A. Please see preceding questions. If past abuse creates a current inability to access services, then the issue may be construed to be current. If this is the case, clearly document in the client record what the current issues are and why the parent(s) needs assistance to access services.

5. **While this new version looks great, is clear and specific, there is a concern with the language in column B; "parents unable to meet the infant's safety needs..." implies that a CPS referral is warranted. Is this the intent? Please consider revising this statement.**

   This comment came up several times so the wording will be changed to "parent(s) needs assistance accessing social, medical or educational resources related to the issue in column A." However, as stated in several preceding questions, if the provider believes the safety of the infant is a stake, a report to CPS must be made.

6. **How will the new ICM components be rolled out? Will current clients be "grandfathered" in?**

   This is currently under development. More information will be forwarded as we make final decisions.

7. **Does a Mental Health diagnosis have to be made by the client's medical provider or can the BHS make this determination? Is there any role for a high score on CES-D?**

   The diagnosis must be made by a qualified medical provider, psychiatrist, psychologist, behavioral health specialist or other qualified health professional staff and documented in the ICM file.

**8. Do Attachment Issues fall under mental health issue? What about stress and post-partum depression?**

As long as the severity of these issues meets the definition of a specific diagnosis found in the DSM IV, they would be appropriately documented in the box entitled "Parent(s) has a current mental health diagnosis". Documentation to support the decision to provide linkages, advocacy and education to this client must also be in the client record.

**9. With regard to alcohol/substance abuse: If a parent was using during the pregnancy but stopped (*whether on their own or with treatment)*, do they still qualify or does abuse have to be active/current?**

This has been re-defined based on provider input/feedback. Any client who has used within the past year is eligible for ICM. If the parent is able to access services without the assistance of a case manager, the parent will be eligible at the lower level of contact. If a parent is involved with other systems such as legal, chemical dependency treatment, CPS, mental health, etc. and needs assistance to access those services, the parent may be eligible for a higher level of contact.

**10. Do the maximum units for either level include the 4 units to complete the Eligibility Screen? 4 units to complete the Eligibility Screening seems a bit long. If we complete it in only 2, can we carry the remaining 2 units over to the total for the rest of the eligibility period? For example, if a lower level client is eligible for a total of 10 units, and this includes the 4 units to screen, but we only us 2, would we have 8 more units for the rest of the eligibility period or do we only get 6?**

Yes. The total units for each level of service include the units used during the eligibility screening. The provider may use up to 4 units to complete the Eligibility Screening. If the screening only takes 30 minutes, the provider may claim 2 units of service and carry the remaining two units over to the remainder of the eligibility period. In the example given in this question, there would be 8 more units available to the client for the remainder of the ICM eligibility period.

**11. Please elaborate on social isolation. We have many clients who are estranged from their families or do not speak English and have difficulty accessing services.**

For First Steps, a parent will be considered socially isolated when he/she is unable to access services that improve the welfare of the infant. This will happen when there are generally few community sources that the parent may tap into in order to receive needed services. A few examples may include; living in a remote area where there is no transportation available to receive services, or the client needs assistance in accessing Medicaid transportation services; the parent needs assistance in accessing Interpreter services; or there is not an interpreter available to provide the service.

**12. Under the lower level of contact, how often can the Case Manager meet with the client?**

The provider will be relied upon to use discretion and professional judgment based on individual client needs. There will be no maximum limits placed on weekly or monthly contact. This is a shift from the current program model. Lower level clients will be allowed a maximum of 10 units while higher level clients will be allowed a maximum of 30 units during the ICM eligibility period. Documentation to support the use of units will be considered when reviewing client records during monitoring visits.

**13. Where do basic health message fall within the scope of ICM?**

During the initial eligibility screening for clients who do not qualify for ICM and throughout the eligibility period for clients who are eligible for either level of ICM services, basic health messages may be incorporated.

**14. What is a "Limitation Extension" and how is one requested? Are there a maximum number of units allowed under an extension? Please give examples of when a Limitation Extension may be requested.**

A limitation extension is what providers currently know as an exception. The process to request a limitation extension will be the same process currently used to request an "exception." Currently, there is no maximum number of units that may be requested for an extension. The units must be used within the ICM eligibility period and documentation will be required to justify the number of units being requested. If we determine in the future that more restrictions or limitations need to be implemented, we will re-visit this issue.

**15. Clarification on the use of Column A and Column B please. If any issue in A has a corresponding check in column B, the client is eligible for the higher level of contact, correct?**

Correct.

**16. Is there a possibility to provide group services under this new model?**

In the short term, the answer is no. However, the team developing this new model recognizes the value in providing group services. The barriers to allowing group services right now lies within the roll out of the ProviderOne system. We may not make any changes to the codes until after ProviderOne is implemented. At that time, we will consider group services for First Steps.

**17. If a client is screened in to a lower level of contact, are they ever eligible to qualify for the higher level?**

Yes. If you screen a client in to the lower level and their circumstance change within the ICM eligibility period, they may receive the higher level of contact. Be sure to document the details and justification for the change in the client record.

**18. Will we be able to bill more than once a month up to the limit?**

Yes. You must follow guidelines in the currently published Billing Instructions.

**19. What is the maximum amount of time allowed for client visits?**

This is determined by the level of client need, the number of units available to the family, the provider's professional judgment and the plan for care. Documentation in the client file must support the amount of units billed.

**20. What is the reimbursement amount?**

There is no change to the current amount reimbursed for ICM services. The current fee-for-service rate per ICM unit is $20.00

**21. Please clarify "Failure to Thrive". It is not clear as currently written.**

The definition has been changed and now reads: Weight less than 3rd percentile on standard growth chart, weight that is less than 80% expected weight for age or a deceleration of growth velocity across two major percentiles. Failure to Thrive is complex and as such, the Case Manager is expected to use professional judgment when this condition exists. Documentation in the client chart to support provision of services based on this issue is required.

**22. If a household is a two parent household, do both parents need to be under 17 years old to qualify for ICM? Is this age limit only until the parent(s) turns 18 or is eligibility based on the parent(s) age when they are eligible for ICM?**

Both parents need to be 17 years old or younger to be eligible for ICM, not under 17 years old. Once determined eligible, the parent(s) may remain eligible through the remainder of the ICM eligibility period.

**23. Would like to see homelessness within the past 6 months as one of the eligibility criteria, and we are concerned that the lack of high school completion/GED is not one of the eligibility criteria.**

While we understand this request, we had to make difficult decisions in order to meet our budget requirements. Because the focus on ICM is to assist parents in accessing services, if a parent is not homeless there is no access issue. If the situation changes and the parent(s) needs assistance to access housing services, then eligibility may be re-considered if still within the ICM eligibility period. All decisions to provide Case Management to clients must be clearly documented in the client record and include the specific circumstances to support why the client needs assistance to access identified services. With regard to high school completion/GED, if the lack of education prevents the parent(s) from accessing services for other criterion listed in column A, be sure to document this in the client record. Non-high school completion or lack of GED does not necessarily mean that the individual is incapable of accessing services.

**24. How is level of eligibility communicated to the state?**

There is no communication requirement to the state per se. It is a requirement to document the level of service in the client record. Justification as to why the level of service was determined and a plan of care to address the issues identified is also required. When state staff or auditors review client files, information in the client record will be used to determine if the services were billed appropriately. Once ProviderOne is operational, the process to change these codes will be requested.

Now with that explanation, if we interpret the question to be asking "Will we need to report any information to the state?" our answer is "yes" but we have not determined what that information will be. The purpose of any report(s) we request will be so that we may keep a close eye on expenditures and quickly make adjustments as necessary. We are still determining the best way to obtain this information. Once a plan is finalized, providers will be informed.

**25. When does this new Form go into effect?**

Providers will begin using the ICM Eligibility Screening Tool on July 1, 2009.

**26. I did not understand from the directions that Column A was the criteria for ICM. Please state more clearly.**

The directions have been updated to more clearly state that Column A is the eligibility criteria.

**27. On the bottom of page 1, the box that says "Referrals, include ICM provider agency" is repetitive of what is at the top where "agency name" is listed.**

The box on the bottom of page 1 was combined with the "Outcome/Next Steps" box.

**28. The space in the boxes at the bottom of page one seem very limited. Also, would you please give examples of what you would like to see in each of the boxes?**

The intent of the screening tool is not to replace the plan of care or client record. It is intended to quickly identify issues, if any, that may negatively impact the welfare of the infant and to determine what level of contact the family qualifies for under ICM. We envisioned just a couple sentences in each box to summarize the Case Manager's findings as a result of the Eligibility Screening.

**Following are a few comments about each of the boxes:**

***Specific Needs of the Infant and Parent(s):*** We are looking for a brief explanation of the family's circumstances. What about the issue in Column A has the parent(s) disclosed that lead you to check the box? Then, if the corresponding box in Column B is checked, what specific assistance is needed? Why did you determine this?

***Referrals – Include ICM Provider Agency:*** This box has been deleted. Because you are tasked with assisting families in accessing services, you will undoubtedly be referring these families to other services either outside of your agency or to specialists within your agency. The client record must capture this information to justify the provision of Case Management services. This information is captured in the Outcome/Next Steps box.

***Educational Material Provided:*** This box is for the Case Manager to document what was given to the family in the form of literature and/or basic health messages. If there is not enough room to document everything, then you may attach a list of material and information that you consistently give all ICM families.

***Outcome/Next Steps:*** If the client does not qualify for ICM, write the reasons here. If the client is eligible for ICM at either level, write the justification here. This box should tell anybody who reviews this record what, if anything was discovered, what services the client needs assistance in accessing, and how the Case Manager will assist the client in accessing identified services.

If the client does not qualify for ICM, the Case Manager may write something like: "*Client not eligible for ICM. Basic Health Messages provided. Client informed s/he may contact this agency at anytime if circumstances change."*

If client qualifies for ICM, the Case Manager may write something like: *"Client eligible for lower level of contact due to current homelessness. Discussed various options for housing including locations of local shelters. Client has been in contact with XYZ Shelter that has room for client and her infant. Follow-up scheduled for tomorrow at 2:00 with client at Shelter."*

**29. I did not see the infant's or parents date of birth on the form. Did I miss it?**

The DOB was not missed. The originator of the DRAFT form was using DSHS form 13-658 revised 02/2008. That version of the form does not contain DOB. Due to amount of information currently on form and our desire to keep it as short as possible, we chose not to include DOB.

**30. On the bottom of page one, you do not list the number of units for either column A or B, yet in the instructions you stated that a low level is 10 units and a higher level is 30 units. Do we fill in the number on page one or will this be an auto fill feature?**

This was an editing error. The units are now reflected in the final version of the form and are the maximum number of units allowed for each level of contact.

**31. Under definition of "parent" could you give an example of "a person who is legally obligated to support the infant" if this person is not a biological parent or one with legal custody?**

This example will typically involve a stepparent who does not have legal custody of an infant, but who, for whatever reason may be court ordered to support the infant.

This will be a rare occasion.

**32. Are column A and B cumulative? That is, can a client get 10 units in column A and upon qualifying for column B, get 30 more units for a total of 40? Or is 30 units the max total?**

Total units are not cumulative. ***Example:*** You screen a client who qualifies for a lower level of contact. You have provided the client with 6 units of service. During the ICM eligibility period, the clients circumstances change that would qualify them for higher level services. You may provide an additional 24 units of service for the remainder of the eligibility period without getting a Limitation Extension.

**33. Will the screening tool itself have a signature line for the client to sign?**

No. The expectation is that the provider will develop a Plan for Care based on individualized needs and professional judgment that is reviewed and agreed upon with the parent.

**34. Are there a maximum number of units per day?**

No. However, use of all units must be justified in the client record.

**35. Can all units be provided in a short time frame based on client needs? For example, all 10 units in a week or 30 units in a month?**

Yes. However, documentation to support the use of units must be in the client record.

**36. We understand that the ICM eligibility screening should be administered during the post-partum period, when possible, with up to 4 units being used. Is the time period to use the remaining 6 units (if Lower ICM contact level) at the standard 2 months post-partum through the infant's first birthday?**

We aren't sure we understand this question, so will try to describe our intent here:
We envisioned the ICM eligibility screening to take place during the MSS postpartum eligibility period whenever possible. If the screening is done during the MSS postpartum period, up to four MSS units may be billed *(or however many units were actually used to do the screening)*. If there are not enough MSS units available, the ICM screening will be conducted at the first opportunity during the ICM eligibility period. The total units used to do the screening will be subtracted from the total units the client is eligible to receive.

***Example 1:*** Parent is screened for ICM during the last month of MSS eligibility. The face-to-face screening meeting took 45 minutes. The client has 18 units left of her MSS eligibility period. You would subtract 3 units from the 18 and the client would have 15 units left for the remainder of her MSS postpartum eligibility period.

***Example 2:*** Parent has 1 unit remaining in her postpartum MSS eligibility period. Because you take a minimum of 30 minutes to screen these women, you will not be able to claim more than 1 unit if you do the screening during the MSS postpartum eligibility period. We recommend connecting with the parent at the first opportunity to screen for ICM eligibility.

***Example 3:*** Parent is screened during the ICM eligibility period. You use 3 units with this parent. If there are no issues identified in Column A, you will document in the client record and may bill for 3 units. If the parent returns anytime within the ICM eligibility period because of issues that do qualify them for ICM, you subtract the 3 units from the total you eventually assign to them based on their level of need.

***Note:*** This response is based on the current train of thought regarding the post-partum MSS eligibility period. This may be subject to change if we determine that to be necessary.

**37. Can any staff person administer the eligibility screening?**

Any Professional member of the MSS Team or ICM staff can complete the screening tool.

**38. Will home visits be allowed? Required? Billed at a different level?**

There are no changes in the type of visits required and amounts reimbursed at this time.

**39. Does the definition of ICM change to include counseling or is it strictly advocacy, linkage and referrals as in the past?**

ICM is advocacy, linkage and referrals, and may include some basic health messages/educational opportunities within the context of these "case-management" activities. Clients should be referred to counseling services if needed. Counseling is outside the scope of ICM and would be billed fee-for-service under the eligible parent's medical ID.

**40. If a client is not eligible for ICM upon her screening, but circumstances change, can she then be screened and enrolled within the one year post-partum period?**

Yes.

**41. If a client qualifies for more than one risk factor in column A, do her services expand beyond the 10 units?**

No. Column A identifies the criterion that makes a client eligible for ICM services at the minimum level. When the client has any identified issue in Column A but the corresponding box in Column B is not checked, you have determined that the issues exist, but that the parent is able to access the needed services to address the identified issues.

***Hint:*** We designed this to allow you the opportunity to follow up with the parent during the eligibility period. Let's say you used 2 units to conduct the eligibility screening and identified 4 issues in column A. Upon further discussion the parent indicated that she is familiar with the resources available to address her issues.

She would qualify for a lower level of ICM services. After you bill for the 2 units, the client will have 8 units left for the ICM eligibility period. You may decide to meet with this client every other month for the remainder of the eligibility to make sure the family's needs are being met. This may be as basic as scheduling a 15 minute check- in two months out before the current meeting ends. Just be sure to document in the client record.

**42. If a client has an illness such as cancer that necessitates surgery that impacts her ability to meet her infant's needs, where would that fit as a risk factor?**

This falls under the box "Parent(s) has a physical limitation or disability." Be sure to document in the client record.

**43. Are multiple births a risk factor?**

No, multiple births are not a risk factor for screening into ICM. At least one of the issues in Column A has to be present in order for any family to qualify for ICM.

**44. If the mother is hospitalized but the father of the baby is providing care, can ICM services be provided based on mom's physical limitation or disability even though the father is able to meet the infant's needs?**

As described in this question, the response is "No". If the father needs assistance accessing services to meet the infant's needs the answer may be yes.